USING RESILIENCE AND INTERVENTION TO UNDERSTAND BPD AND CREATE BETTER TREATMENT METHODS: A LITERATURE REVIEW

by

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Abstract

Current research on Borderline Personality Disorder (BPD) focuses on risk factors and the effectiveness of dialectical behavior therapy (DBT) as a treatment method. However, little has been researched or written about resilience, intervention, or prevention. This review discusses 11 studies pertaining to resilience, intervention, and DBT. Factors that play into someone being resilient, as well as elements of intervention methods that are related to improvement in symptoms, are also explored. These factors are then compared with the techniques used in DBT to see if there is any overlap. By identifying patterns and finding any overlap, factors that have been shown to have a positive effect on reducing someone's susceptibility or symptoms can then be implemented into prevention and treatment efforts.

KEY WORDS: Borderline Personality Disorder, resilience, psychotherapy, treatment

Using Resilience and Intervention to Understand BPD and Create Better Treatment Methods

Borderline Personality Disorder (BPD) is a Cluster B personality disorder that affects between 1.6 and 5.9 percent of the general population (DSM-V, 2013). Characterized by unstable moods and an inability to regulate emotions, BPD is detrimental to both those who suffer from it and to their loved ones. Furthermore, BPD is heavily stigmatized in the mental health community and may be branded as untreatable because of the person with borderline disorder's lack of desire and/or ability to enter into and complete treatment. Currently, the favored treatment for BPD is dialectical behavior therapy (DBT), which focuses on helping patients cope with negative thoughts in a constructive and healthy manner. Although DBT has proven to be successful, its effectiveness appears to be mostly limited to decreasing self-destructive thoughts and actions.

The development of BPD tends to focus on the experience of child abuse, and little consideration is given to the influence of biological factors. In general, a more complete explanation is that the culmination of biological factors, such as a sensitive temperament, and environmental factors, such as an unstable home situation or child neglect, may lead to the development of BPD. While research regarding resilience and BPD is severely lacking, sibling studies suggest that there are indeed certain factors that can lead to resilience against BPD despite the presence of risk factors. In terms of child abuse or neglect, resilience involves healthy, productive coping skills on the victim's behalf that allows them to experience trauma while mitigating potential negative consequences. Resilience to BPD is similar, with the addition of the individual being able to cope and react in such ways that they do not end up developing the disorder.

Like resilience, little is known about effective intervention methods, but the studies that exist suggest paths forward. The goal of this review is to compare the knowledge about resilience and effective intervention with the practices that are used in DBT, which could potentially open doors into creating more successful treatment and prevention methods. The review will be organized such that articles about the same topic (sibling studies, intervention, etc.) will be compared to one another and then compared to other articles of different topics in the discussion. Directions for future research will also be explored.

Intervention

Intervention for BPD has been dominated by the development and implementation of Dialectical Behavior Therapy. However, other types of interventions have been investigated. An experiment by Salzer, Cropp, and Streeck-Fischer (2014) looked at 28 adolescents between the ages of 14 and 19 who had been diagnosed with BPD according to DSM-IV criteria. These individuals underwent psychodynamic therapy for an average of 29 weeks. The therapy focused on mentalization-based treatment and improvement of interpersonal skills. For the individuals who completed the treatment, the researchers found that there were "significant improvements in four relevant outcome measures regarding global psychological distress, psychosocial impairment, interpersonal problems, and characteristic features of [BPD]" (377). However, when compared to individuals who were not diagnosed with BPD ("normative data"), these numbers were still quite high.

Although not specifically related to BPD, a review by Roberts et al. (2017) discusses the successfulness of changing personality traits through intervention. In looking at 207 studies, they found that clinical interventions resulted in personality changes over an average of 24 weeks. Results showed that emotional stability was the most effected trait, which is useful in trying to

understand intervention methods for BPD given the high level of emotional instability that BPs have. Citing a study from Roberts et al. (2001), they mention that changing one trait in an individual is much more effective than trying to change multiple traits at once (119). In their results section, they explain that emotional instability was the one trait that experienced the most change, and that cognitive-behavioral therapy produced the best treatment results (126). Lastly, the authors note that intervention lasting between four and eight weeks seemed to be ideal for changing personality traits; less than four will not produce long-lasting results, and more than eight will not lead to further changes.

Resilience

Resilience can be defined very generally as the failure to experience negative effects (or the mitigation of those negative effects) despite exposure to negative events (e.g., traumatic effects). Several studies have explored the idea of resilience in the context of BPD. In a study by Skodol et al. (2007), positive childhood experiences were found to be a major factor that contributed to resilience. Besides BPD, this study looked at schizotypal, obsessive-compulsive, and avoidant personality disorders. Over a span of four years, 523 individuals who were diagnosed with these disorders were evaluated to understand what effects positive childhood experiences had on successful remission. For BPD, the researchers found that "positive interpersonal relationships" (1106) were key in successful remission. A larger number of positive childhood experiences was positively correlated with successful remission in all of the personality disorders that were studied. The researchers also found that there was no correlation between any child abuse suffered and the successfulness of remission. While not related to BPD, the authors also mentioned that avoidant and schizotypal personality disorders were easier to successfully treat when the patients were younger.

Emotional Awareness as a Moderator

Though it has not been studied thoroughly, emotional awareness has been suggested as a potential moderator (or protective factor) in the development of BPD. In their study, Westbrook and Berenbaum (2017) looked at 293 adults to understand the relationship between emotional awareness and BPD. Citing child abuse as a risk factor for BPD, they sought to locate which specific BPD symptoms, if any, could be affected by emotional awareness. Participants were chosen based on how the met the DSM-IV's criteria for BPD. Childhood physical abuse, sexual abuse, and emotional abuse were measured, as were emotional awareness and negative affect. The researchers found that all three types of abuse were positively correlated with the development of BPD. Furthermore, different combinations of abuse and emotional awareness and negative affect resulted in different presentations of BPD symptoms. The individual's level of emotional awareness was related to the type of attachment style. Since the data showed that emotional awareness can moderate the effects of childhood emotional and physical abuse, the researchers suggest that focusing on emotional awareness in therapy may be useful in effectively treating and intervening in BPD.

Sibling Studies

Resilience has perhaps been most successfully explored in the context of sibling studies. Two articles, one by Laporte, Paris, Guttman, Russel, and Correa (2012) and one by Paris, Perlin, Laporte, Fitzpatrick, and Destefano (2014), investigated pairs of sisters to understand why one sister had developed BPD and the other sister had not. Laporte et al.'s experiment looked at 56 pairs of sisters, with each pair consisting of a BP and a non-BP sister. They explain that using a sibling design allowed for the elimination of certain variables since the sisters grew up in the same household environment and with the same parents. For the study, the authors interviewed

the sisters via telephone to determine eligibility, and the sisters met with the researchers in person twice. Self-reporting and interviewing were the two measures used to determine the presence and symptoms of BPD. The study uncovered several key differences in the lives of BP women compared to their non-BP sisters. Although both sisters in each of the pairs reported experiencing child abuse and/or neglect while growing up, those with BPD had certain personality traits and "temperamental vulnerabilities" (325) that their sisters did not have. Researchers found that sexual abuse, relationships with parents, and child abuse were not good predictors of BPD development. However, they did find that the major difference between BPs and non-BPs was the relationships they had with their peers. Those with BPD tended to have poor, unstable peer relationships, while those without BPD had much better relationships with their peers.

Meanwhile, the study by Paris et al. looked at 12 pairs of sisters; again, one sister had BPD and one did not. The researchers interviewed each pair of sisters using open-ended questions. They found that the sisters tended to have opposite responses to these questions; for example, the sister without BPD would describe her sister as "negative" (ex., negative outlook on life), and the sister with BPD would describe her sister as "positive" (positive outlook on life). The women with BPD were less able to regulate their emotions and struggled to plan for the future (although this was not true for every woman). The sisters that did not have BPD tended to have better boundaries with their family members, were supported by adults in the community (ex., teachers, clergy), positive relationships with peers, and an ability to accept the past and move on. Overall, "personal strength" (207) and support from friends and from adults in the community were identified as two common factors in resilience.

Treatment

As previously noted, DBT is the primary treatment method for BPD. For example, Bendit (2014) provides a brief summary of the evidence that supports the effectiveness of DBT. In examining a number of studies, he found that the effectiveness of DBT varied depending on different factors, including substance abuse. In general, DBT was more effective than treatment-as-usual, but said effectiveness was mostly related to decreasing parasuicidal behaviors. Depression and feelings of hopelessness did not appear to be affected by DBT (146). DBT was also compared to general psychiatric management and was found to be more effective. Bendit notes that this study had more validity than the treatment-as-usual studies because of the larger population studied and "a balance of allegiance to both models by the investigators" (146). Ultimately, Bendit argues that the evidence for the effectiveness of DBT may have slightly better results than those produced by the treatment-as-usual and general psychiatric management methods, but these results are not significant enough to say that DBT is the only successful option for treatment.

In fact, there is some evidence that there are significant limitations to DBT. For example, Panos, Jackson, Hasan, and Panos (2013) used a meta-analysis to understand the effectiveness of DBT. They looked at several specific categories, including the effectiveness of DBT in decreasing parasuicidal behavior, reducing attrition, and treating depression. Overall, they found that DBT was most effective in combating self-harm and suicidal behaviors, was somewhat helpful in reducing attrition, but was not very helpful in treating depression. They suggest that DBT is a good starting point in lowering patients' self-destructive behaviors and increasing compliance. They argue that more research should be done on both DBT and other forms of

treatment for BPD, as there currently is not enough data to say that DBT is effective in the long term.

Similar to Bendit and Paris, O'Connell and Dowling (2013) find that the effectiveness of DBT is restricted to lessening suicidal and self-harm thoughts and behaviors. Although this means that DBT is, in a way, effective, the authors argue that more research should be done to see how else the treatment can be useful. They also note that this does not necessarily mean that DBT is *the only* effective treatment, because there is little research comparing DBT to other forms of treatment. In other words, DBT is only seen as an effective treatment because there is a lack of evidence to support any other forms of treatment.

There is also some suggestion in the literature that targeting specific subtypes of BPD may be important in development new interventions. For example, Sleuwaegen et al. (2018) conducted a study to see if DBT helped with controlling certain BPD subtypes. They looked at 145 inpatients who had been diagnosed with BPD and had gone through three months of DBT. The behavioral inhibition system (BIS), the behavioral activation system (BAS), and effortful control (EC) were studied, and the subtypes included were "emotional/disinhibited," "low anxiety," and "disinhibited" (330). They found that the low anxiety subtype showed the least amount of improvement after three months of treatment. The researchers point out that, with this discrepancy of effectiveness in mind, more research should be done regarding what specific aspects of treatment are helpful for each subtype.

Discussion

Though DBT certainly introduced a sea-change in how BPD was managed in a variety of treatment settings, it is clear that resilience has not been well-investigated in the context of DBT. Although the literature has certainly shown that DBT has a positive impact on those suffering

from BPD, this effectiveness is in lowering self-harm and suicidal thoughts and behaviors. There does not appear to be data suggesting that DBT has the ability to ameliorate other key symptoms of BPD, such as emotional dysregulation and the inability to maintain healthy relationships. Furthermore, there is concern that DBT may not have a lasting effect on the patient. However, there have also been few longitudinal studies conducted on the long-term effectiveness of the treatment.

The two sibling studies are the best resources for understanding what specific elements in someone's life might factor into resilience. By studying siblings, researchers were able to control variables found inside the home (ex., parents and home environment) and look deeper into the internal mechanisms (ex., temperament) and external factors (ex., relationships with peers/classmates) of each subject's life. Both studies found several traits common in resilient subjects. The major trait identified was positive relationships with people outside the home (ex., friends, classmates, adults in the community), and this was also shown to be the most important of all elements uncovered by researchers. Also, the study by Skodol et al. (2007) on resilience came to the conclusion that "positive interpersonal relationships" (1106) and positive childhood experiences were key in both resilience and successful long-term reduction of BPD symptoms, despite common genetic heritage.

Those three studies demonstrate that forming and maintaining positive relationships with the people in one's life act as the best defense against both the development of BPD and the continuation of symptoms. However, neither "positive relationship" or "poor relationship" are defined or assigned certain characteristics by any of the authors. Because relationships have been identified as a crucial element in the development, or lack thereof, of BPD, it is important that

what constitutes a positive relationship and what constitutes a poor relationship is clearly spelled out.

In examining the factors that are involved in resilience, emotional regulation is the only element that is implemented into DBT. Even then, the focus on emotional regulation is minimal. Considering that the most common outcome of successful DBT treatment is the reduction of suicidal and self-harm thoughts and behaviors, it is possible that DBT may be better in lessening loved ones' stresses and concerns than in lessening BPD symptoms in the sufferer. If a loved one no longer has to worry about a BPD sufferer self-harming or attempting suicide, DBT may be viewed as "enough" treatment for the sufferer, which is clearly not true. Importantly, Bendit (2014) argues that DBT did nothing to counter depression or feelings of hopelessness, and Panos et al. (2013) also remark that depression is least affected by BPD. Overall, this suggests that DBT has little to no impact on the emotional facets of BPD. Because the foundation of BPD is emotional instability, it is clear that more research needs to be done to create a treatment program that specifically addresses these issues.

Salzer et al. (2014) and Roberts et al. (2017), as well as Westbrook and Berenbaum's (2017) provide more encouraging evidence for treating the emotional foundation of BPD. Mentalization-based treatment, which is a novel method that focuses on making the patient aware of their thoughts and feelings and the thoughts and feelings of people around them, is shown to have promising results. In Salzer et al.'s experiment, some of the core symptoms of BPD (troubled relationships, psychosocial impairment) were positively affected by approximately 30 weeks of mentalization-based treatment. Furthermore, Roberts et al. found that clinical interventions (ex., supportive therapy and cognitive behavioral therapy) had the ability to change personality traits over approximately 24 weeks. As noted earlier, although this article did

not focus on BPD, emotional instability was found to be one trait that could experience positive change through intervention. As for emotional awareness, Westbrook and Berenbaum argue that someone's emotional awareness, or lack thereof, is related to the type of attachment style they form (ex., anxious or insecure). The authors believe that helping patients gain emotional awareness is an important step in intervening in and treating BPD.

Recommendations for Future Research

When comparing the results and conclusions made by these articles, it becomes clear that DBT does not make use of what researchers have identified as factors that are helpful in developing resilience against BPD symptoms. It will be helpful to continue gathering information on the possible causes of BPD, but only if there is also a focus on understanding resilience. By discovering what factors can make someone resilient and why, researchers may be able to suggest new treatment methods that focus on combating the emotional instability that characterizes BPD as opposed to only decreasing self-harm and suicidal thoughts and behaviors. Furthermore, more research should be done to understand what makes intervention successful. Similar to resilience, understanding successful intervention may allow researchers and clinicians to identify what specifically leads to patients being successfully treated. This information can then be used to create and test new treatment methods. Overall, there are several types of experiments researchers could do to try and answer these questions.

First, it would be worthwhile to do more sibling studies and, if possible, study males instead of females to see if there are any similarities or differences in what factors result in resilience. Next, researchers should look deeper into mentalization-based treatment. Because this is a relatively new form of treatment, it has not been studied or implemented very much, and it is worth studying to see if its effects can reach further than those of DBT. Finally, although this

should not be a primary concern of researchers in terms of resilience and treatment, looking into emotional invalidation during childhood as a risk factor for BPD development could provide more information about the emotional foundation of BPD. By understanding what factors into emotional invalidation and how said invalidation affects the individual, researchers may be able to use this information to suggest new ways to tackle patients' emotional instability.

Conclusion

Based on the available research, it is clear that while there is some information regarding effective intervention, prevention, and treatment methods, more research needs to be done to explore new methods. Although DBT is a start in terms of treatment and is shown to have some success in treating individuals with BPD, this method is simply not sufficient and should be viewed as a first step towards successful treatment instead of being the only method of successful treatment. Because DBT focuses on lowering self-harm and suicidal thoughts and behaviors, it is clear that treatment methods targeting emotional distress should be researched, implemented, and studied. Overall, understanding the relationship between resilience, effective intervention, and BPD, and using this information to form new treatment methods, may be a necessary step in making successful treatment advances.

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